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20 June 2009

1859-2009 Celebrating 150 years in pharmacy

C+D Awards 2009 winners revealed

Special Awards Supplement inside

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Dispenser

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Levonelle® One Step is on telly.
Expect an increase in demand.

Levonelle One Step has launched its first ever TV campaign, raising awareness of emergency contraception and its availability at pharmacies among an even greater number of women. **Stock up to meet demand.**

Levonelle® One Step™ 1500 microgram tablet
Prescribing Information (Refer to the Summary of Product Characteristics (SmPC) before prescribing)
Presentation: One tablet containing 1500µg levonorgestrel **Uses:** Emergency contraception within 72 hours of unprotected intercourse or failure of contraception. Not recommended for young women under 16 without medical supervision. **Dosage and administration:** One tablet taken as soon as possible, preferably within 12 hours, and no later than 72 hours after unprotected intercourse. Vomiting, or other causes of malabsorption (such as Crohn's), might impair the efficacy of Levonelle One Step. If vomiting occurs within 3 hours of taking the tablet, another tablet should be taken immediately. Use at any time in the menstrual cycle unless period is overdue. After use, advise using barrier methods until next period. Regular hormonal contraception can be continued. **Contraindications:** Hypersensitivity to any of the ingredients of the preparation. **Warnings and precautions:** Levonelle One Step is suitable only as an emergency measure. Advise women presenting for repeat courses to consider long-term methods of contraception. Levonelle One Step does not prevent a pregnancy in every instance. If timing of intercourse is uncertain or occurred more than 72 hours earlier, conception may have already occurred. Following treatment, if the next menstrual period is abnormal or more than five days late, women should be referred to a doctor so that pregnancy may be excluded. If pregnancy occurs, evaluate for ectopic pregnancy. Ectopic pregnancy risk is low. Ectopic pregnancy may continue despite uterine bleeding. Explain importance of follow-up appointment and possible alteration to timing of next period (few days earlier or later). Exclude pregnancy in users of regular hormonal contraception if no bleeding occurs in the next pill free period. Not recommended for women with severe hepatic dysfunction. Emergency contraception does not protect against sexually transmitted infections. Repeat administration within a menstrual cycle is not advisable due to possible disturbances of the cycle. Efficacy might be impaired in women with malabsorption syndromes or by interaction with concurrent drugs including barbiturates (e.g. primidone), phenytoin, carbamazepine, herbal medicines containing Hypericum perforatum (St John's wort), rifampicin, ritonavir, rifabutin, griseofulvin. Medicines containing levonorgestrel may increase the risk of ciclosporin toxicity. Women with malabsorption syndromes or on interacting medicines should be referred to a doctor. Levonelle One Step contains 142.5mg lactose. Take this into account for women with galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption. Epidemiological studies indicate no adverse effects of progestogens on the foetus but there is no data available for doses greater than 1.5 mg levonorgestrel. Animal studies showed virilisation of female foetuses at high doses. Levonorgestrel is secreted into breast milk. Advise breast feeding women to take the tablet immediately after a breast feed. **Side-effects:** Nausea, low abdominal pain, fatigue, headache, dizziness, breast tenderness, vomiting and diarrhoea. Bleeding patterns may be temporarily disturbed. **Trade price:** £13.83 per tablet **Legal classification:** P **PL Number:** PL 05276/0020 **PL Holder** Medimpex UK Limited, 127 Shirland Road, London, W9 2EP **Distributor:** Schering Health Care Limited, The Brow, Burgess Hill, West Sussex, RH15 9NE. Levonelle One Step is a registered trademark of Bayer Schering Pharma AG (formerly Schering AG). Date of revision: March 2009

Bayer HealthCare
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Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Bayer Schering Pharma; Tel: 01635 563500, Fax: 01635 563703, E-mail: phdsguk@bayer.co.uk

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Group Editor
Gary Paragpuri MRPharmS
01732 377688
News Editor
Max Gosney 01732 377315
Reporters
Jennifer Richardson 01732 377088
Zoe Smeaton 01732 377441
Chris Chapman 01732 377503
Online Editor
Tom Hawkins 01732 377284
Clinical & CPD Editor
Gavin Atkin 01732 377239
Contributing Editor
Adrienne de Mont FRPharmS
Acting Marketing Editor
Sarah Thackray 01732 377600
Group Production Editor
Fay Jones 01732 377396
Deputy Group Production Editor
Harriet Kinloch 01732 377112
Group Art Editor
Richard Coombs 01732 377528
Designers
David Farram 01732 377120
Jo Konopelko 01732 377231
Office Manager
Elaine Steele 01732 377621
(fax): 01732 367065
esteele@cmpmedica.com
Marketing Manager
Emily Miles 01732 377612
Commercial Director
Ruth McKay 020 7921 8456
Advertisement Managers
Daniel Spruytenburg 020 7921 8126
Deborah Heard 020 7921 8119
Senior Sales Executive
Andrew Walker 020 7921 8123
Online Senior Sales Executive
Jonathan Franklin 020 7921 8333
C+D Data
Devi Patel (Operations Manager)
01732 377451
Colin Simpson (Price List Controller)
01732 377407
Darren Larkin (Electronic Data Controller) 01732 377457
Maria Locke (Specialist Systems Controller) 01732 377212
Sandra Drawbridge (Input Clerk)
01732 377254
Price List (fax): 01732 377559
Projects Director
Patrick Grice MRPharmS
01732 377296
Training Development Managers
Asha Fowells MRPharmS
01732 377463
Kinna McConochie MRPharmS
01732 377487
Projects Administrator
Pauline Sanderson 01732 377269
Production
Katrina Avery 01732 377674
Managing Director
Phil Johnson 01732 377633
Email
firstinitialsurname
@cmpmedica.com

PPA ABC

TABPI Awards 2008
Winner for news coverage

> THE MEDICINES ACT WAS NEVER MEANT TO BE USED TO DESTROY THE CAREERS OF PHARMACISTS WHO MADE GENUINE ONE-OFF MISTAKES

No pharmacist can claim to have been untouched by the news of Elizabeth Lee's prosecution for a dispensing error. Emotions have ranged from disbelief to horror at the suspended jail sentence handed to the former locum, and the sector has been united in its condemnation of the way the Medicines Act was used to prosecute one of its members.

There was a real fear that pharmacists would become risk averse as they sought to distance themselves from the threat of prosecution. The Medicines Act was meant to protect the public against receiving adulterated products in the days when extemp dispensing was the norm. It was never meant to be used to destroy the careers of pharmacists who made genuine one-off mistakes.

So the news this week that the MHRA and the Crown Prosecution Service (CPS) are in dialogue over agreeing a position to ensure pharmacists do not face criminal prosecution under the Medicines Act for simple dispensing errors will be warmly welcomed by the profession. While it is not a permanent solution, it could well lead to an interim measure being put in place that allows pharmacists to practise without fear of being locked up for minor errors.

Announced by England's chief pharmacist Keith Ridge to a packed meeting room at the House of Commons this week, the proposed measure does come with a caveat or two, however. Dr Ridge was clear that any new agreement will not mean pharmacists can absolve themselves of all responsibility when mistakes are made.

The new rule will give pharmacists parity with other healthcare practitioners when they make errors and there will have to be a careful balance between accountability of the individual making an error and the desire to have a truly blame-free culture. But more than this, it should give community pharmacists the freedom to show true innovation in the delivery of care to patients.

And innovate they can. This week we reveal the winners of the C+D Awards, and every one of the 54 individuals and companies who made it on to the shortlist are proving just what can be achieved in pharmacy. From bespoke medication reviews to vaccination services, from prescribing to anticoagulant clinics, the sheer diversity of services demonstrates that the sector is up for the challenge of delivering world class services.

Such services were almost unthinkable back in 1968 when the Medicines Act was passed. Thank goodness it looks as if the law will finally catch up with the extraordinary progress now being made by community pharmacy.

Gary Paragpuri, Editor

C+D Awards celebrate sector's leading lights

Outstanding work in community pharmacy recognised

Jennifer Richardson
jrichardson@cmpmedica.com

C+D celebrated the talents and hard work of those at the leading edge of community pharmacy at its second annual C+D Awards this week.

Fifty four shortlisted pharmacists, technicians, support staff, pre-reg graduates and companies gathered to find out who had been named, among other accolades, Pharmacy Business Leader of the Year and Pharmacy Technician of the Year.

The winners were presented with their trophies in front of more than 400 guests in a ceremony at The Grosvenor House Hotel in London's Mayfair on Wednesday.

Among those due to collect their awards as C+D went to press was Community Pharmacist of the Year Michael Maguire, of FI Maguire (Marton Pharmacy) in Middlesbrough. Mr Maguire impressed the judges with his passion and focus, which led to him being invited to join a PCT working group to set up a funded cardiovascular risk assessment service.

Also included in the 15 winners was New Pharmacist of the Year James Wood, of Sheffield's Wicker Pharmacy. The judges praised Mr Wood's early involvement in the profession as "truly inspiring".

See next week's C+D and www.chemistanddruggist.co.uk/awards for all the pictures and interviews with the winners from the C+D Awards 2009, in association with the NPA.

The winning Pharmacy Team of the Year – Murrays Healthcare of Malvern

And the C+D winners are...

Pre-registration Graduate Pharmacist of the Year
Gursharan Rattan, Leyton Orient Pharmacy, Leyton, London

New Pharmacist of the Year
James Wood, Wicker Pharmacy, Sheffield

Pharmacy Manager of the Year
Bernard Mweseka, Day Lewis Pharmacy, North Woolwich, London

Pharmacy Technician of the Year
Lynn Kennywell, Dean & Smedley, Ashby-de-la-Zouch, Leicestershire

Pharmacy Assistant of the Year
Sally Ingram, Lloydspharmacy, Earlsdon, Coventry

MUR Champion of the Year
Justin Gilbody, The Co-operative Pharmacy, Tibshelf, Derbyshire

Clinical Service of the Year
The Co-operative Pharmacy

Retail Service of the Year
CDHN, Newry, Northern Ireland

Business Development of the Year
AAH Pharmaceuticals

Green Award
Murrays Healthcare

Pharmacist Prescriber of the Year
Valerie Sillito, Boots, Aberdeen

Pharmacy Innovation of the Year
Community Pharmacy Scotland

Pharmacy Business Leader of the Year
Martin Green, Community Pharmacy Scotland

Community Pharmacist of the Year
Michael Maguire, FI Maguire (Marton Pharmacy), Middlesbrough

Pharmacy Team of the Year
Murrays Healthcare, Prospect View Health Centre, Malvern, Worcestershire

- Read more about the winners and finalists in the C+D Awards supplement in this issue

MBE winner 'just a normal pharmacy'

A London pharmacist has spoken of his surprise and delight at being awarded an MBE in the Queen's Birthday Honours.

Ebrahim Kharodia, of I T Lloyd Pharmacy in West London, was recognised for "services to pharmacy in central London and to charity in Malawi".

Mr Kharodia said he was thrilled with the award and very grateful to the patients who nominated him for the honour.

He told C+D: "We're just a normal pharmacy, but I think maybe it's my one-to-one contact with my patients and customers... I'm very grateful to my patients, customers and doctors around the area."

In addition to his pharmacy work, Mr Kharodia collects donations from customers and travels to Malawi, where he supports HIV orphanages and other children's charities. **CC**

See Mr Kharodia's charity work
www.chemistanddruggist.co.uk

NHS fraud team investigates specials

An anti-fraud team is investigating the cost to the NHS of specials dispensing in the community.

C+D understands that the NHS Counter Fraud and Security Management Service (CFSMS) investigation follows concerns raised by PCTs about escalating costs of specials dispensing without significant increases in the numbers of items.

A CFSMS spokesperson said it never confirmed or denied investigative activity. But PSNC confirmed to C+D that it had alerted all LPCs to the investigation, after it discovered the CFSMS had written to PCTs about it.

"At the moment it's not clear what the issue is, if indeed there is an issue," PSNC head of NHS services Alastair Buxton said. "We don't want to jump to any conclusions."

The CFSMS's Pharmaceutical Fraud Team has written to specials manufacturers seeking samples of invoices, to be tracked back to actual prescriptions, C+D understands.

PSNC had "for some time" been in discussions with the Department of Health "with the idea of trying to take a more standardised approach to the pricing of more commonly prescribed specials", Mr Buxton added. He could not reveal further details of any progress that had been made. **JR**

"The NHS needs to save £20bn: what will this mean for you?"

Read Georgina Craig's view online at www.chemistanddruggist.co.uk/opinion

Industry lobbies CPS for dispensing error reprieve

MHRA seeks pledge from prosecutors until laws are reviewed

Max Gosney
mgosney@cmpmedica.com

A deal to protect pharmacists from criminal prosecution for one-off dispensing errors is under discussion, England's chief pharmacist has revealed.

Health chiefs will push the Crown Prosecution Service (CPS) to show leniency while existing medicines laws are overhauled, this week's all-party pharmacy group (APPG) meeting heard.

The measures will act as a stop gap until the legislation surrounding dispensing errors can be reviewed in 2010 or 2011, England's chief pharmacist said.

Keith Ridge said: "It will take time to consider how best to develop the Medicines Act. This interim solution, which is very dependent on CPS's attitude, is from our point of view the way forward."

Talks between the MHRA and CPS were a priority, he said. The chief pharmacists in Wales, Scotland and NI had sought assurances from equivalent legal bodies, Dr Ridge revealed. Any changes to medicines laws must meet public expectations over safety, while avoiding unneccesary penalties for pharmacists, he added.

The pharmacy minister will be monitoring progress between the MHRA and the CPS, Dr Ridge said.

If successful, the discussions could see prosecutors subject to sterner tests before they can bring criminal charges against pharmacists who make dispensing errors.

Jeremy Holmes, RPSGB chief executive, said: "There's an opportunity for a short-term solution and part of that may be guidance to CPS on what passes the public interest test for criminal cases."

The comments came at the APPG meeting on dispensing errors.

Demands for mistakes to be decriminalised have intensified since the sentencing of locum Elizabeth Lee for a dispensing error in April.

Dr Ridge called on pharmacists to adopt an open culture on reporting errors. The profession must treat patient safety as a priority. He called on staff to speak out on unsafe working conditions and for employers to unite to improve safety.

C+D news editor Max Gosney delivers readers' support for decriminalisation to the all-party pharmacy group event

Pharmacy leaders applaud proposed changes

Pharmacy leaders gave immediate backing to proposals that could prevent criminal charges for single dispensing errors.

PSNC chief executive Sue Sharpe told the APPG meeting that proposed measures would bring huge comfort to the profession.

Mark Koziol, PDA chairman, said greater leniency must act as a springboard for better error reporting: "If we can get this announcement about the CPS closing the back door then we should appeal to pharmacists to get more involved in reporting errors. It's shocking so few errors are reported."

Howard Stoate, APPG chair, said an agreement with CPS would be of "huge reassurance" to pharmacists.

Meeting attendees also called for clearer drug packaging designs to prevent dispensing errors. The National Patient Safety Agency said it recognised the issue of lookalike packs and progress was being made. **MG**

Dispensing errors campaign hits national news

he campaign to decriminalise ispensing errors has burst into the ational spotlight by topping the ealth agenda on the BBC News ebsite and gaining radio coverage.

On June 16, the health section of he BBC News website led with a ory that covered the Elizabeth Lee se and pharmacy's campaign to ange the law. It also included tails of the early day motion DM) tabled by Howard Stoate MP, ich had 85 signatures as C+D nt to press.

C+D news editor Max Gosney is quoted by the BBC emphasising the results of the C+D and PDA Union Salary Survey 2009, which found that 4 per cent of pharmacists have had suicidal thoughts in the past year.

The BBC story coincides with Radio 4's PM programme on dispensing errors.

For more details, including how you can get your MP to sign the EDM, go to www.chemistand druggist.co.uk. **CC**

The dispensing error campaign has captured national media attention

New pharmacy minister

Mike O'Brien is set to replace Phil Hope as pharmacy minister. The announcement came at this week's APPG meeting. Mr O'Brien moves across from the Department of Energy and Climate Change.
www.chemistanddruggist.co.uk

Flu pandemic plans

Health officials pledged more details on how pharmacy will be used to tackle swine flu as the virus moved to pandemic status last week. Health secretary Andy Burnham said details were on the way as WHO declared a pandemic after raising its alert level to six.
www.chemistanddruggist.co.uk

WAG reviews services

The Welsh Assembly Government has set up a group to review and improve community pharmacy services in the country. Group chair Chris Martin, a community pharmacist, told C+D his aim was to ensure pharmacy's engagement in the country's new local health boards.
www.chemistanddruggist.co.uk

Pharmacy Order response

The Department of Health and the Scottish Government have published a joint consultation response to the draft Pharmacy Order 2009. The Order will now be laid before parliament along with the consultation report and, if approved, will establish the General Pharmaceutical Council (GPhC, the profession's future regulator) in statute.
www.chemistanddruggist.co.uk

Correction

The NPA's Neal Patel has pointed out that pharmacy contractors who wish to offer the HPV vaccine via a private patient group direction require authorisation by the Care Quality Commission and not their PCT, as reported in C+D, June 13, p22/24. PCTs are not involved in private PGDs. Alternatively, appropriately trained pharmacists may administer the vaccine if requested by a GP on a prescription form.

See the pics from the C+D Awards 2009

Dispensary talk

Who is to blame for drug shortages?

"I blame everything on Gordon Brown. But it's manufacturers – they're trying to stop us and everybody else parallel exporting. At the end of the day it's the government who should give them a kick."
Chris Forster, Fairman Chemist, Newcastle Upon Tyne

"Supply problems are the bane of my life. Ultimately, I believe it's the manufacturers, and some wholesalers, putting pressure on the NHS."
Linda Bracewell, Baxenden Pharmacy, Accrington

Web verdict

Manufacturers 60%

Wholesalers 11%

Parallel traders 14%

The government 15%

Armchair view: After last week's vote debacle, it's nice to have a clear winner: six out of 10 respondents believe manufacturers are to blame for the clog in the supply pipeline.
Next week's question: How long does it take you to check your NHS prescription services payments?
www.chemistanddruggist.co.uk

GPs speak out against pharmacy health checks

Motion citing workload fears tabled at LMC conference

Zoe Smeaton

Pharmacy-based health checks, such as cardiovascular risk assessments, have come under fire from doctors.

GPs warned checks could increase their workloads and they called for funding to compensate.

The attack came in a motion put forward by Oxfordshire Local Medical Committee at last week's LMC conference. Pharmacy's role in checks "should not be developed without considering the resource implications for [general] practices", the motion said.

This is the second successive year pharmacy health checks have come under attack. At last year's LMC conference GPs warned the national vascular screening programme could lead to confusion and a duplication of efforts if pharmacists referred too many patients to GPs.

Oxfordshire LMC chief executive Dr Paul Roblin told C+D: "If they [pharmacists] are doing more primary care detection then more cases will be identified... our workload will go up." He said this should not happen without an increase in funding.

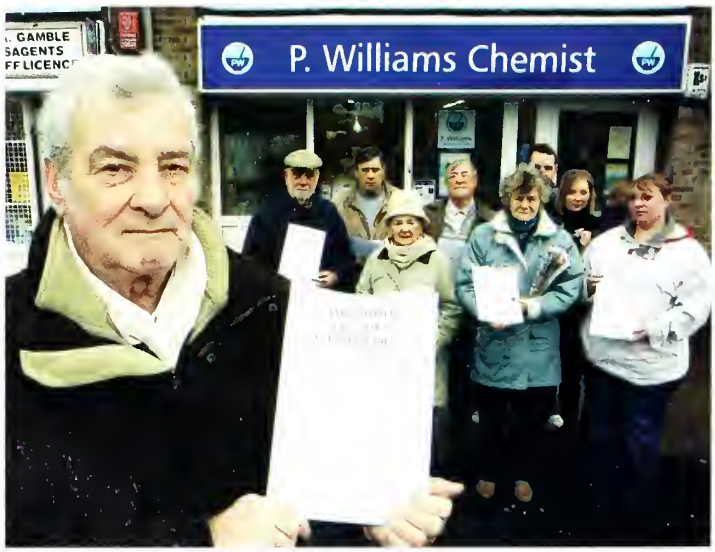
Although the matter was not debated at the conference, Dr Brian Dunn of the General Practitioners' Committee agreed: "The problem with screening is that it always increases workload because you are always going to get false positives."

He stressed that this was not a pharmacy specific issue, but agreed he would prefer the checks to be carried out by GPs so that they could benefit from the additional income.

Alastair Buxton, head of NHS services at PSNC, said some GPs were happy for pharmacists to provide the checks, as long as quality was ensured and GPs received any results. And he stressed that community pharmacists could reach patients who didn't visit GPs.

The GPs put forward almost 700 motions for the conference, with one stressing that payments for enhanced services should be consistent between GPs and pharmacists.

On other issues GPs agreed with pharmacy, passing motions deploring the "waste of money" being spent on new health centres in areas where there was no need.

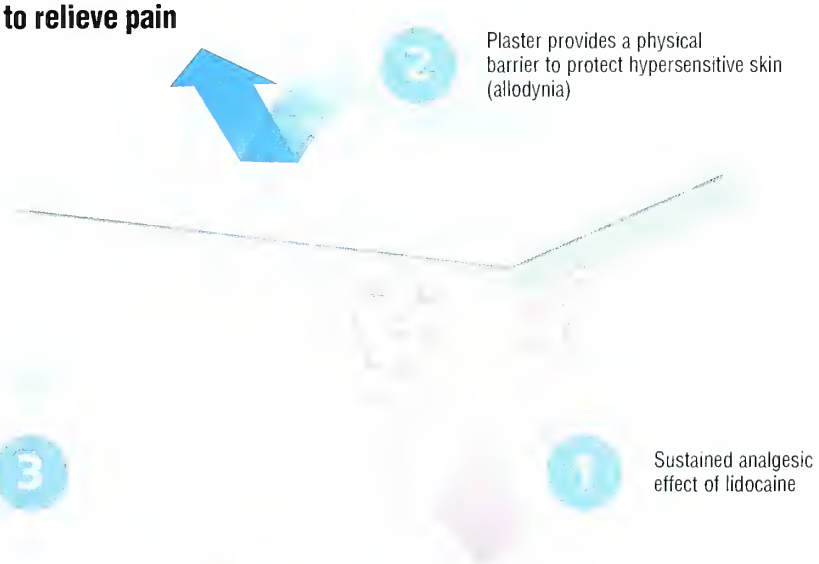


A Co-operative pharmacy earmarked for closure is set to launch a range of innovative health services after being saved by its local PCT. P Williams Chemist in Awsworth, Notts, was one of 14 Co-operative pharmacies scheduled to close after being determined financially unviable. However, following a spirited local campaign, including a petition with more than 500 signatures, Nottinghamshire County PCT elected to negotiate with the multiple to save the pharmacy. The pharmacy has now written to locals to pitch possible services, including smoking cessation, minor ailments, health checks and sexual health. The services are due to launch in September 2009.

Keeping on top of neuropathic pain

Versatis is an elegant plaster medicated with 5% lidocaine licensed for the treatment of neuropathic pain associated with post-herpetic neuralgia.

Versatis works in 3 ways to relieve pain



How Versatis should be applied

Patients should be advised to follow the step-by-step instructions in the leaflet that is included in the Versatis pack. Remind them that:

- The skin should be unbroken, clean and dry
- The skin should be cleaned of any creams or lotions before you apply the plaster
- If the painful area of skin has hairs on it, they can be cut off using scissors. Do not shave them off
- Each plaster should be pressed onto the skin for at least 10 seconds to make sure it sticks firmly

The plaster is worn 12 hours on; 12 hours off

It is important that Versatis is in contact with the skin for 12 hours. It should be worn either for 12 hours during the night or for 12 hours during the day (depending on when the pain is worse). Patients should avoid contact with water whilst wearing the Versatis plaster.[1]

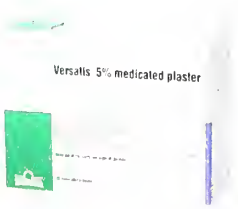
Why Versatis should be tried for at least 4 weeks

A General Practice study of 322 PHN patients found that after repeated application, the majority of patients (66%) experienced a reduction in pain within 1 week of treatment with Versatis.[2]

Around half of the patients who didn't improve in the first week, improved in the 2nd week with further improvement 2-4 weeks after starting therapy.[2]

Dispensing Versatis

The 30-plaster pack has been designed to provide a patient with a month's treatment, using 1 plaster per day. Each pack contains 6 sachets of 5 plasters. The sachets should not be opened to dispense individual plasters, as the hydrogel in the plasters will dry out.



Versatis Prescribing Information

Versatis 5% medicated plaster. Refer to the Summary of Product Characteristics (SPC) for full details on side effects, warnings and contra-indications before prescribing. **Presentation:** Versatis is a medicated plaster (10cm x 14cm) containing 700 mg (5% w/w) of lidocaine in an aqueous adhesive base. Indication: Symptomatic relief of neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia, PHN). **Dosage and method of administration.** Adults and elderly patients: Use up to three plasters for up to 12 hours, followed by at least a 12 hour plaster-free interval. Cover painful area once daily. Apply the plaster to intact, dry, non-irritated skin (after healing of the shingles). Remove hairs in affected area with scissors (do not shave). Remove the plaster from sachet and its surface liner before applying immediately to the skin. Plasters may be cut to size. Re-evaluate treatment after 2 to 4 weeks. Patients under 18 years: Not recommended. **Contra-indications.** Hypersensitivity to active substance, any excipients, or local anaesthetics of amide type (e.g. bupivacaine, etidocaine, mepivacaine and prilocaine). Do not apply to inflamed or injured skin (e.g. active herpes zoster lesions, atopic dermatitis or wounds). **Warnings and precautions:** Should not apply to mucous membranes or the eyes. Plasters contain propylene glycol which may cause skin irritation, methyl parahydroxybenzoate and propyl parahydroxybenzoate which may cause allergic reactions. Use with caution in patients with severe cardiac impairment, severe renal impairment or severe hepatic impairment. In animals, metabolites of lidocaine have been shown to be genotoxic, carcinogenic and mutagenic, with unknown clinical significance. **Interactions:** No clinically relevant interactions have been observed in clinical studies. Absorption of lidocaine from the skin is low. Use with caution in patients receiving Class I antiarrhythmic drugs (e.g. tocainide, mexiletine) or other local anaesthetics. **Pregnancy and lactation:** Do not use during pregnancy or breast-feeding. **Undesirable effects:** Very common (≥10%): administration site reactions (e.g. erythema, rash, pruritus, burning). Uncommon (>0.1%-≤1%): skin injury, skin lesion. Very rare (<0.01%) but potentially serious: anaphylaxis, hypersensitivity. Adverse reactions were predominantly of mild and moderate intensity. Systemic adverse reactions are unlikely. See SPC for full details. **Overdose:** Unlikely. If suspected, remove plasters, provide supportive treatment (see SPC). **Legal classification:** POM. Marketing Authorisation number, pack sizes and basic NHS cost: PL 21727/0016, 30 plasters (£72.40). Marketing Authorisation Holder: Grunenthal Ltd, Regus Lakeside House, 1 Furzeground Way, Stockley Park East, Uxbridge, Middlesex, UB11 1BD, UK. Date of text: October 2008. V0320

References:
1 Versatis Summary of Product Characteristics
2 Katz NP *et al* Pain Medicine 2002; 3(4): 324-332

versatis
5% lidocaine medicated plaster
WORKS WHERE IT HURTS

Adverse events should be reported. Reporting forms and information can be found at: www.yellowcard.gov.uk. Adverse events should also be reported to Grünenthal Ltd (tel: 0870 351 8960).

LICENSED FOR THE TREATMENT OF NEUROPATHIC PAIN ASSOCIATED WITH POST-HERPETIC NEURALGIA

V0555 Date of preparation of item: May 2009

Introducing new Doublebase Wash

Avoiding Soap~The Doublebase Way

Doublebase™ Wash

isopropyl myristate, liquid paraffin

Cleanses, Moisturises & Protects

~More harmony for dry skin~

Now available from your local wholesaler PIP code: 345-7629 Prosper code: 368563 AAH code: DOU47N

new

Doublebase™ Emollient Wash Gel

isopropyl myristate, liquid paraffin

'Healthcare professionals should inform children with atopic eczema and their parents or carers that they should use emollients and/or emollient wash products instead of soaps and detergent-based wash products.'

NICE clinical guidance 57 – Atopic eczema in children - http://www.nice.org.uk/nicemedia/pdf/CG057NICEguideline.pdf

'Soap is very drying to the skin and is best avoided by people with eczema. The hands are particularly at risk, as they are washed more frequently. Liquid soaps/cleansers and perfumed products should also be avoided as they tend to irritate skin with eczema. Emollient soap substitutes do not foam but are just as effective at cleaning the skin as soap. Soap substitutes can either be applied before bathing, showering or washing, or while in the water.'

National Eczema Society – http://www.eczema.org/treatment.html

It is well documented that washing with conventional soap bars or liquid soaps can have a drying effect on the skin. These detergent based wash products are alkaline, and tend to remove the natural oils from the skin. Their fragrances can be irritant to sensitive skin.

Doublebase Wash is a highly emollient alternative to soap. It has three actions:

- The non-ionic soap substitute cetomacrogol gently and effectively cleanses the skin.
- The humectant, glycerol, attracts water, to moisturise the skin.
- The high oil content softens the skin and provides protection against dryness.

Doublebase Wash is specially designed for use by the sink and comes in a convenient 200g pump dispenser.

Doublebase Wash is available on NHS prescription.

Doublebase Wash - a cleansing, moisturising and protective soap substitute for dry skin conditions, such as those associated with eczema and psoriasis.

Prescribing Information

Active ingredients: isopropyl myristate 15% w/w, liquid paraffin 15% w/w.
Uses: A highly moisturising and protective soap substitute for dry or chapped skin conditions which may also be itchy or inflamed.
Dosage: For adults, the elderly and children. Use regularly and as often as necessary. Use the product to gently wash the skin. Rinse off and pat the skin dry using a soft towel, avoid rubbing as this can irritate the skin.
Contra-indications, warnings, side-effects etc: Please refer to SPC for full details before prescribing. Do not use in cases of known sensitivity to any of the ingredients.
Pack size and NHS price: 200g pump dispenser (OP), £5.29.
Legal Category: P

Product Licence number: PL0173/0402.
Marketing authorisation holder: Dermal Laboratories, Tatmore Place, Gosmore, Hitchin, Hertfordshire, SG4 7QR. 'Doublebase' is a trademark.
Date of preparation: June 2009.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Dermal.

700407 DXX207/JUN09

Prescription switching – are we any nearer a resolution?

As the agency responsible for processing NHS prescriptions launches a quiz to aid submissions, **Zoe Smeaton** asks if a solution to erroneous switching has yet to be found

Last year pharmacists across the UK spoke out against the incorrect switching of prescriptions from exempt to paid after a new computerised NHS system was introduced. Underpayments totalling several thousands of pounds for some contractors triggered a £3.5 million compensation package.

Almost one year on, has the problem really gone away?

Graham Phillips, of the Manor Pharmacy Group in Hertfordshire, says not at all. He says NHS Prescription Services (NHS PS) is still switching his scripts inaccurately and "needs to get its house in order". Mr Phillips' latest payment had three switches, all of which were found to be in error when challenged.

At Shaftesbury Pharmacy, Lila Thakerar, who last year experienced more than 100 switches some months, tells a similar story. She still sees errors that cost her between around £100 and £300 per month.

As well as switching, some contractors are seeing mistakes on their statements where they are simply not being paid for some items.

PSNC is monitoring the situation, and says there have been improvements, brought about by measures such as staff performance management at NHS PS. But it adds that it is still identifying some problems and receiving calls from contractors on the matter.

So will a new quiz, designed by NHS PS to help pharmacists "improve their knowledge on whether to submit their prescription forms as exempt or chargeable", solve the problems?

The answer from readers approached by C+D was a resounding no. Although several said it would be a useful tool and could be used in particular to help train staff, most commented that the quiz was too basic to be any real help.

As Ms Thakerar says: "If achieving a 100 per cent feedback [on the quiz] still results in approximately £300 deducted monthly as unpaid prescription charges, there are loopholes in the system."

Chris Forster, managing director of Fairman Chemists in the north east, explains that in his pharmacies the problem is not a lack of understanding of the system, just the fact that a great deal of care is needed to ensure every prescription is processed completely accurately.

One example where pharmacists are losing out is on exempt prescriptions on which the date of birth has been handwritten. Mr Phillips calls the refusal by the NHS PS to treat these as exempt without a declaration "absurd". PSNC agrees the penalty for not obtaining a completed exemption declaration is "unacceptably high".

The committee wants such scripts to be returned to pharmacies to "support transparency and help restore contractor confidence in NHS Prescription Services".

Last year C+D reported on significant switching problems faced by many readers

And this transparency seems to be the key to resolving the remaining issues. Ms Thakerar says pharmacists should be allowed to see their switched prescriptions so they can learn from mistakes.

Raj Patel of Mount Elgon Pharmacy in Wimbledon agrees: "I think contractors need to get detailed information on what are the common returned items, ie a top 50 list."

But while that would help contractors to improve the accuracies of their payments where switches are occurring, it doesn't address what some see as the bigger issue: pharmacists are giving up precious time dealing with these problems.

The NPA says a recent membership survey showed the "vast majority still think the agency [NHS PS] is having a negative impact on their ability to run an efficient pharmacy". And Mr Phillips says many contractors he speaks to spend "fully two days at the end of each month checking and re-checking their prescription bundles".

He asks: "Why is the exemption system so complex that we have to devote so much time and resource to trying to understand it? What does the NHS want? Dedicated box checkers with no time for clinical work, or a high-trust, easy-to-understand and transparent exemption system?"

The answer to this question seem obvious, but the solution might be harder to find. Mr Phillips believes the key is to keep up the pressure or NHS PS so it is forced to acknowledg the extent of the problem.

And with PSNC still monitoring the situation and lobbying for change, the advice for now really does seem to be keep checking, and keep reporting those errors to both PSNC and NHS PS.

NHS PS responds

An NHS Prescription Services spokesperson said feedback confirmed some contractors still needed help to improve their understanding of how to apply the rules around exemption.

The quiz was something they could be referred to to help with this, it said.

NHS PS declined to comment on whether the switching situation had improved, but the spokesperson said it still processed claims with an accuracy level of 99.8 per cent and was continually looking for ways to improve accuracy.

Asked about the switching of scripts with handwritten dates of birth, the spokesperson referred pharmacists to the Drug Tariff, which states the exemption only applies without a declaration where the date is "automatically printed".

NHS PS declined to comment on returning these scripts to contractors, as PSNC has called for, and also on pharmacists being reimbursed omitted from their payments.

Take the NHS quiz

www.chemistanddruggist.co.uk/news

The Responsible Pharmacist

Whatever role you play in your pharmacy business, from October 1 you will have to follow some new SOP guidelines to comply with the Responsible Pharmacist regulations. The best way to be prepared is to start planning early, so here's what to do.

PART 3 Updating your pharmacy SOPs

As the responsible pharmacist (RP) you are legally responsible for establishing, maintaining and reviewing pharmacy procedures. Even if you are not writing the SOPs, you must ensure they enable the safe and effective running of the pharmacy; check if they need amending, reviewing or updating; and ensure staff are aware of and work to them.

You can view template SOPs at www.responsiblepharmacist.com, where you can also find a full list of what your SOPs need to cover under the new regulations.

SOPs can be as detailed as you like as long as they ensure the safe, effective running of the pharmacy, but they must be easy to understand and follow. And there are a number of things to consider:

Format: Electronic format is easier to update but printed SOPs can be easier to read and understand.

Storage: Paper SOPs should be kept for 15 years from the date they were last effective and electronic copies kept indefinitely.

Records: Old versions of SOPs should be marked as such and new ones marked with the date of preparation, the name of the person establishing them and their signature. New SOPs should be given a progressive version number.

Staff: Pharmacy staff must be made aware of the content of SOPs that apply to them and these should be readily available. Even casual staff must read, sign and date the record sheet if the SOP applies to their tasks.

Reviews: Review SOPs at least every two years or if patient safety is affected, such as by a dispensing error, or new guidance introduced. The date and person reviewing should be recorded on the SOP along with the next review date.

Amendments: These are temporary changes due to a change in the pharmacy's circumstances, such as a staff member being off sick. They must be authorised by the RP, who should sign and date and check this amendment complies with the law and professional standards.

PART 4 Focus on independent contractors, in C+D, July 4.

SOPs checklist

- **Locums:** try to be familiar with a pharmacy's SOPs before arriving, checking staffing, how you sign on as RP and where SOPs are kept
- **Employees:** check who is establishing new SOPs and work with employers to ensure these are in operation and staff understand them. You may be involved in writing SOPs to comply with the regulations too
- **Owners and superintendents:** support RPs in complying with the regulations, such as by providing template SOPs. Don't force RPs to impose procedures RPs do not agree with and allow flexibility to tailor procedures locally
- **All pharmacists:** templates are available to download at www.responsiblepharmacist.com for use as a guide when writing, updating or checking SOPs

Don't quite know where the Responsible Pharmacist regulations will leave you? The NPA's head of information Michelle Styles is on hand with the answers. Email haveyoursay@cmpmedica.com and see FAQs at www.responsiblepharmacist.com

Full Marks tackles head lice with spray

SSL International is launching a spray version of its organic Full Marks Solution to help make it easier for families to treat head lice.

Containing cyclomethicone and isopropyl myristate, the odourless spray is designed to be convenient to use and contains no traditional insecticides. It is designed to work by damaging the lipid coat of the louse, causing dehydration, shrinkage and death.

The product has a 10-minute treatment time so does not have to be left on overnight. Two applications seven days apart may be necessary to kill any lice that have emerged from eggs since the first application.

The Full Marks range has been relaunched to simplify consumer choice. It now comprises four sizes of solution (including spray) plus detector and removal combs. All the solutions come with a removal comb.

Over the past two years, a 37 per cent decline in sales of traditional insecticides (IRI all outlets from March 2007-09) shows consumers are choosing more non-insecticidal treatments, says SSL International.

Price: spray £11.73/150ml
SSL International
Tel: 0870 122 2689

Family can chew over Equazen Omega-3

Vifor Pharma has launched Equazen Eye Q chews in a 30s pack to give parents an opportunity to trial the product with their children. "If they like the taste, customers can then trade up to a larger family pack," says the company.

The strawberry-flavoured chews, which contain naturally sourced high EPA Omega-3 fish oil with Omega-6, are suitable for all the family over the age of three and contain no additives.

Vifor Pharma says the chews "may help maintain certain aspects of brain function including learning ability".

A new brand identity has also been introduced across the Equazen range. Cookie the polar bear will increasingly feature on the brand's merchandising units and promotional material over the coming months.

"Cookie was designed to create a brand personality that consumers could engage with and he also acts as an ideal in-store signpost for the Equazen brand," said Louise Fair, senior brand manager at Vifor Pharma.

Price: £4.79/30
Vifor Pharma; tel: 0870 241 5621

Listerine is strong and sensitive

Johnson & Johnson has added a sensitive variant to its bestselling Listerine range. The company claims Listerine Total Care Sensitive offers the benefits of the other products in the mouthwash range, with potassium nitrate providing additional protection against tooth sensitivity.

The launch is being supported by a £6 milllion media spend, that will include a TV ad due to run in late August/early September, and a press campaign in women's magazines and consumer mailout, both of which will start in autumn.

The promotional activity will also involve a search for the UK's "most strong and sensitive man" and a survey to find a celebrity equivalent.

Price and Pip code: £2.49/250ml, 344-9436; £4.19/500ml, 344-9444
Johnson & Johnson
Tel: 01628 822222

Chefaro calorie reducer

Chefaro aims to drive growth in the slimming aids category with a new supplement designed to help weight management.

XLS Calorie Reducer tablets contain chitosan, a natural active ingredient that works by binding and absorbing nutritional fat, says Chefaro. The tablets do not affect the carbohydrates in the food.

The tablets are suitable for consumers who want to maintain or reduce their weight, says the company.

As the tablets dissolve rapidly, they can be taken just before a meal and should be swallowed with sufficient liquid (300ml). The tablets should not be taken by anyone who has an allergy to shellfish.

The product is being supported by a £1 million national TV advertising campaign, which begins this month. Point of sale material is available.

Price and Pip code: £19.99/30, 302-3207
Chefaro UK; tel: 01202 449752

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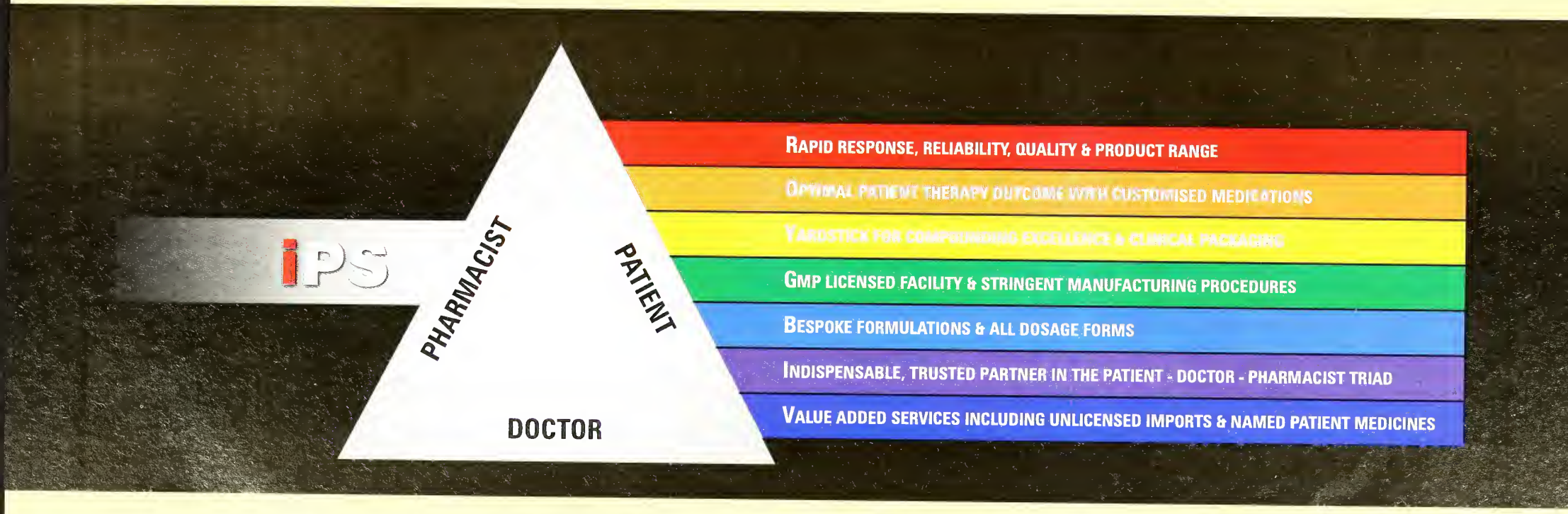

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41 Central Avenue, West Molesey, Surrey KT8 2QZ
Tel: 0208 481 9720 Fax: 0208 481 9729 E-mail: info@ipslabs.ws

iPS Extemp Labs — Formula Magistralis Secundum Artem

Compounding Solutions for Pharmacy

Lamisil frees feet for that summer feeling

Lamisil will be on TV screens until the end of August as part of a £1 million investment by Novartis Consumer Health. The 'footsie' ad highlights the emotional benefit of freeing feet from athlete's foot and enjoying the barefoot feeling.

The campaign will also feature on gym TV and posters in 560 gyms.

A training module for pharmacy staff, point of sale material and consumer information are available.

Novartis Consumer Health
Tel: 01403 218111

Venlafaxine tablets

Venlalic XL 75mg, 150mg and 225mg tablets (prolonged release venlafaxine) have been launched by Dallas Burston Ashbourne. The company said the tablets are designed to be small and easy to swallow and the 225mg dosage tablet has been introduced to help ensure patient compliance.

Pip codes: **75mg 344-8891; 150mg 345-0608; 225mg 345-0616**
Dallas Burston Ashbourne
Tel: 01858 525643

Hactos update

Hactos Cough Mixture is now available again from AAH Pharmaceuticals. The traditional liquid herbal remedy is for the symptomatic relief of coughs, colds and catarrh.

Price: **£3.45/150ml**
Hubert AC Thomas & Company
Tel: 01554 835512

Benadryl ALLERGY RELIEF

On TV next week

Alli: All areas
Benadryl Allergy Relief: All areas
Canesten: All areas
Clarityn: All areas
Compeed Blister Plasters: All areas except GMTV
Corsodyl: All areas
Deep Freeze Cold Spray: ITV, Sat, five
DulcoEase: A, HTV, CTV, W, MGMTV, Sat
Lanacane Anti Chafing Gel: All areas
Levonelle One Step: All areas
Magicool & Magicool Plus: All areas except Sat
Merial Frontline Spot On: All areas except five
Odor-Eaters: All areas
Piriton/Piriteze: All areas
XLS Calorie Reducer: GMTV, Sat, C4
PharmaSite for next week: **LipoBind** – windows, **LipoBind** – in-store, **LipoBind** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

MAM soothers look to east

MAM is launching a new soother collection featuring 12 Japanese rabbit designs. Moshi Moshi Kawaii soothers feature small stylised rabbits with their own colour and pattern that reflect their personality. Kawaii means cute in Japanese but also embodies values like care, innocence and charm.

The soothers feature a curved shield for comfort, generous air holes, anti-slip inside surface and a soft orthodontic teat that adapts to baby's mouth.

The packaging features MAM's partnership with The Foundation for the Study of Infant Deaths to promote its safe sleep message.

Price: **£4.49**
MAM UK; tel: 020 8943 8880

Vote Yes for Pharmacy

Use your vote to build a new professional leadership body

You have told us that a successful professional leadership body is important to you.

You have told us you want an influential body which actively supports, represents and advocates pharmacists and the profession. One that will speak with a strong voice to build a better profession. One that is committed to helping you with your CPD so you keep up-to-date and provide a quality service to your patients.

Now you have a chance to secure this future, by voting 'yes' to the changes to the Society's Royal Charter – the ballot opens on 22 June. You will be voting for a body which is free from regulatory responsibility and totally focused on supporting you – so you can be the best you can.

How to vote

You can vote by post, by phone, online or by text message.

For further details on how to vote or to find out how you can help shape the new body to ensure the products and services meet your needs, visit **www.pharmacypib.com** or call **0808 168 5141**

RPSGB is working with the profession to build a new professional leadership body for pharmacy

www.pharmacypib.com

Space – the final frontier

There has been a shortage of space in this pharmacy for as long as I can remember. I've always needed an extra shelf for stock, an extra couple of drawers for paperwork, more cupboard space for bottles and bags, the list is endless. But as script volume increases and our clinical ambitions expand we are bursting at the seams.

This pharmacy has had a number of refits over its long and illustrious career but it simply can't be made any bigger. Space has been swallowed up by the demands of modern practice, such as the consultation room, additional computer terminal, improved medicines counter and mountains of paperwork. More clinical services are likely to demand a bigger consultation room, another computer terminal and so on.

X Pharmacy's internal space wars are extremely competitive, with shop vs dispensary battles taking place every day. Margaret and Jean want more space to display OTC medicines, and less space taken up with dispensed scripts awaiting collection. Anne and I want that corner overflowing with shop stock for our dispensary bags and bottles. Minor battles are won and lost every week, but no one can win the war.

We've worked hard to make best use of what we've got. Such as only keeping dispensed prescriptions on the collection shelf for a month and not making up owings till the patient returns make for slight improvements but ultimately create more work for us. No documents or magazines older than a month are kept in the pharmacy unless essential, but now when I do need to look for an older document it takes me longer to search the stockroom. Space saving measures are now becoming very time consuming. If only I could expand out onto the pavement in the summer, like some of the local cafes…

If some of the other fundamental barriers to progress in this profession, mainly remuneration and government inactivity, are overcome, space could be the factor that limits further progress. Unless, of course, there is enough money for a relocation. But that seems increasingly unlikely in view of impending NHS cuts (C+D, June 13, p4).

I'm left with no choice but to allow the next refit, which isn't due any time soon, to 'steal' some shopfloor space for the dispensary and medicines counter. This makes sense, and reflects the business turnover, where less and less comes from shop lines. But I've been resisting this on behalf of our loyal customers and distress purchasers, who I fear will get their prescription at the supermarket if they're forced to do all their shopping there.

It's the customer who will lose out in our space war. How much the business will suffer from virtually no shopfloor, I'm not sure. The only winner will be the one with all the space – the supermarket.

> IF ONLY I COULD EXPAND OUT ONTO THE PAVEMENT IN THE SUMMER

An alternative to criminal prosecution

It's a like a Shakespearian tragedy. Elizabeth Lee made a dispensing error that was not fatal. She was prosecuted for supplying the wrong product and labelling it incorrectly. In my view, she should not have been prosecuted at all, but the CPS brought charges.

The case should have been dealt with in the Magistrates Court but was sent to the Crown Court. Instead of sending it to the local Crown Court, her case was sent to the Old Bailey, which deals with the country's most serious criminal cases. Mrs Lee pleaded guilty to the labelling offence and she should have been given a conditional discharge or community sentence. Instead, she got a prison sentence. Where did it all go wrong? If Mrs Lee is too upset to appeal, how should the profession try to put things right?

The Code for Crown Prosecutors says when deciding whether to prosecute there must not only be sufficient evidence to secure a conviction, they must also decide if a prosecution is needed in the public interest. The Code lists common public interest factors in favour of and against prosecution.

Decisions to prosecute are not based on counting the factors for and against the public interest. A balancing exercise is required. In weighing up the factors, Crown prosecutors must also take into account the views of the victim or victim's family. Although Mrs Lee's error did not cause the death of the patient, press reports of the conduct of the patient's family in court suggest they may have pressed for a prosecution.

The RPSGB has announced it will lobby ministers to decriminalise dispensing errors. It is easy for C+D readers to see why it is not in the public interest to expose pharmacists to the possibility of an Old Bailey trial whenever a dispensing error is made. However, if ministers insist on retaining criminal sanctions for dispensing errors, I have a suggestion.

Clearly, the Society will have a better understanding than the CPS of the seriousness of cases involving pharmacists and of the potential implications of a prosecution. The head of the CPS is the attorney general, whose functions include giving guidance to prosecutors about the public interest. The attorney general should be asked to tell prosecutors not to prosecute under the Medicines Act without first consulting the Society.

There is ample justification for this, since the Medicines Act entrusts the Society to prosecute for offences under the Act. If the Society had not allowed the power to prosecute to fall into disuse over the years, I doubt the CPS would have stepped into its shoes in Mrs Lee's case.

David Reissner is a solicitor and head of healthcare at Charles Russell LLP, where he is a partner

> IF MRS LEE IS TOO UPSET TO APPEAL, HOW SHOULD THE PROFESSION TRY TO PUT THINGS RIGHT?

Features

Benchmark

New!
Accredited by the RPSGB

Benchmark is an accredited training course for dispensary assistants.

Written by a team of experienced community pharmacists and medical writers, Benchmark has been mapped to both the Pharmacy Services S/NVQ2 and the Skills for Health framework that will supersede the NVQ later this year.

Meets RPSGB requirements for dispensing assistants

To register your staff, or to find out more call 01732 377269. Alternatively visit www.chemistanddruggist.co.uk/benchmark

Drug-induced skin reactions

Skin complaints are common, but how can you determine if they are an adverse drug reaction?

Professor Janet Krska

Mr H asks for a Yellow Card form because he wants to report a skin reaction his wife had to a cream she bought from a herbalist (he has brought the cream to show you). He has heard about the Yellow Card scheme from the leaflet[1] he received before an MUR a few weeks ago. How can you help?

Skin reactions are common ADRs. Almost any medicine can cause some type of skin reaction, but fortunately most are not serious and resolve on withdrawal of the drug. However, some are part of a bigger syndrome and can even be life-threatening.

Regardless of severity, there is a risk of recurrence on re-challenge and pharmacists should be aware of skin reactions arising from drug therapy, record them and use these records to prevent recurrence. This is particularly important for allergic skin reactions to prevent subsequent drug exposure causing a more severe reaction.

Skin reactions can arise from immunological causes – including allergic or hypersensitivity reactions – or may be due to a drug's pharmacological properties. Allergic reactions are most frequently related to the active ingredient, but it is important to remember many excipients cause allergic reactions. Changing from one brand to another can therefore precipitate skin reactions.

Skin conditions caused by drugs can be difficult to distinguish from natural skin conditions, so the timing of the condition in relation to drug initiation is crucial. This means that careful questioning and exploring the patient's drug history through PMRs are important. Generally skin reactions are most likely to occur early in treatment. Commonly implicated drugs are in table 1 overleaf.

Common allergic reactions

The skin is particularly prone to manifesting reactions to drugs and other substances because mast cells and T cells are present throughout the skin layers. Topical products are most likely to cause allergic skin reactions, followed by injections and then oral formulations. Both chemically-mediated and cell-mediated responses are involved. Foreign substances on the skin surface (topical products) or within the deeper layers (systemic products) release histamine and other chemical mediators from mast cells. Drugs can also act as haptens, which are incomplete antigens that can stimulate antibody production only in combination with a particular protein. Penicillins are the most common drug hapten, resulting in an IgE-mediated response and subsequent sensitisation, thus increasing the risk of a more serious reaction on repeated exposure.

Histamine release in the epidermis leads to urticaria – red itchy swollen areas. Angioedema, swelling of the dermis or subcutaneous tissue, is less common than urticaria, and results from leakage of fluid from skin blood vessels most often in the eyelids, lips, tongue or genitals. If the mucous membranes of the airways are involved, it can lead to airways obstruction and death. Anaphylaxis can involve urticaria, angioedema, airway obstruction and a rapid fall in blood pressure.

Aspirin and other non-selective NSAIDs are probably the most common cause of urticaria, which may occur through leukotriene release and inhibition of prostaglandin formation. Patients with chronic urticaria or angioedema are at increased risk of developing a skin reaction to NSAIDs.

Contact dermatitis is a common condition, often involving nickel, substances in cosmetic preparations and plants. However it can also occur with topical antibiotics and steroids. It is seen as reddening and scaling of the skin or worsening of the condition for which the antibiotic or steroid is being used.

Common non-allergic reactions

Skin rashes are the most common type of non-allergic reaction, often caused by penicillins, particularly ampicillin. Rash occurs in 5 to 10 per cent of children receiving ampicillin and is a generalised dull red, maculopapular rash, appearing three to 14 days after starting therapy. It normally begins on the trunk and spreads over most of the body. It may be most intense at pressure areas, elbows and knees, but is often not itchy. A non-allergic ampicillin rash does not require stopping the ampicillin and in theory it is acceptable to use penicillins in these patients. Unfortunately it is not always possible to be certain if an individual has a non-allergic rash or an allergic reaction, but if urticaria or angioedema are present, this suggests an allergic reaction.

60-second summary

This article (module 1482) is worth 1 hour of the following CPD competencies:
G1a, G1c, G1e, C1b, C1d, C1f
See http://tinyurl.com/6bcx7b

The Update May winner is Tim Hazelwood of Telford.

Fixed drug eruptions may have a genetic basis and are caused by excipients and a wide variety of drugs, most commonly sulfonamides, tetracyclines and NSAIDs. They occur anywhere on the skin or mucous membranes, especially the genitals, but are generally not serious, resolving on drug withdrawal. If the drug is taken again, they appear in exactly the same place. In this case, re-challenge with the suspected drug is acceptable as a means of identifying the causative agent.

Photosensitivity is a skin reaction to ultraviolet light. Symptoms including burning or pigmentation, which develop on exposure to sunlight, not necessarily hot sun, and sometimes even through glass. The most commonly implicated photosensitising drugs are amiodarone, thiazides and phenothiazines, especially chlorpromazine. Some antibiotics, including tetracyclines and quinolones, can also cause photosensitivity reactions. Many topical products including cosmetics can cause photo-allergic reactions, usually localised to the area of application.

For details of rare, serious skin reactions such as Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN), see this article online at www.chemistanddruggist.co.uk/update.

Worsening of conditions

Some drugs can increase the severity of existing skin conditions, including acne and psoriasis, but drugs are unlikely to worsen eczema or atopic dermatitis. Steroids, including oral contraceptives, can worsen acne. Lithium can worsen or precipitate either acne or psoriasis. Other drugs that can worsen psoriasis include terbinafine, chloroquine and some DMARDs.

Management

For any skin condition suspected to be drug-related it is extremely important to obtain a detailed medication and allergy history, including history of atopy. As many drugs can cause skin reactions, the timing of the eruption in relation to starting a medicine is the key factor in determining the cause. Most skin reactions occur within hours, days or a few weeks of a new treatment so, in any patient taking multiple medicines known to cause skin problems, the one most recently started should be suspected initially as the most likely cause.

Management involves stopping the causative agent, and symptoms such as urticaria, erythema or maculopapular rashes usually resolve rapidly. Fixed drug eruptions often resolve over one to two weeks after stopping the drug.

Topical treatments that may be of benefit include emollients, especially for contact dermatitis and scaling, and calamine lotion for pruritus and erythema. Crotamiton cream or lotion may be useful for urticaria. Oral antihistamines can be given for urticaria and angioedema, while oral or injectable steroids may be needed for anaphylaxis and more serious conditions.

Photosensitivity reactions are best prevented by avoiding or limiting sun exposure. High factor sunscreens are recommended if the drug cannot be changed.

One of the most important roles for pharmacists is preventing patients from being exposed to the drug again, because of the risks of anaphylaxis or more serious reactions including SJS and TEN. Therefore it is essential to record the reaction in the PMR.

Table 1 Skin reactions, appearance and drugs that can cause them

Urticaria (oedematous wheals accompanied by erythema and pruritus): penicillins, sulfonamides, aspirin, NSAIDs, opioids, excipients

Angioedema (swollen skin, commonly facial): ACE inhibitors, NSAIDs

Contact dermatitis (redness, irritation, dry cracked skin): neomycin, bacitracin, benzocaine, sulfonamides, hexachlorophene, thiomersal

Erythema (redness due to inflammation): allopurinol, penicillins, erythromycin, nalidixic acid, nitrofurantoin, sulfonamides, antituberculous drugs, barbiturates, captopril, carbamazepine, furosemide, gold, lithium, phenothiazines, phenytoin, thiazides

Morbilliform (well-defined marks on the skin, which are not raised), morbilliform rash (small, red macular lesions, confluent in places – looks like measles) and papular rash (small raised lesions: almost any drug can cause these types of rash or eruption; penicillins are probably the most common cause)

Fixed drug eruptions (round or oval red or purple lesions): variety of antibacterials, NSAIDs, PPIs, ACEIs

Pemphigoid (large blisters containing serum [bullae]): captopril, cefalosporins, penicillin, DMARDs, furosemide

Pigmentary changes (patches of skin discoloration: brown, grey or blueish, depending on drug): phenytoin, chloroquine, oral contraceptives, amiodarone

Acne-type eruptions (red papules, usually on the face, beginning suddenly): isoniazid, lithium, phenobarbitone, phenytoin, steroids, oral contraceptives

Photosensitivity (dermatitis, resembling sunburn on light-exposed skin): amiodarone, retinoids, chlorpromazine, nalidixic acid, NSAIDs, quinolones, sulfonamides, tetracyclines, thiazides, tricyclic antidepressants

Telangiectasia (dilation of superficial blood vessels): potent topical steroids

Purpura (haemorrhagic marks, commonly on the lower legs): warfarin, aspirin, chlorothiazide, quinine, sulfonamides, penicillins

Helping patients to report

Do you have patient Yellow Cards in your pharmacy?

These cards differ from the ones you use as a health professional, so do not offer a form from the BNF or MIMS. Patient Yellow Cards come with information about how to report and have an integral envelope to send to the MHRA. All pharmacies should have received these. You can request them from the MHRA on 020 7084 2000, by emailing info@gsi.gov.uk or by post: MHRA, CHM Freepost, London SW8 5B.

Patients can also report online at www.yellowcard.gov.uk or by freephone on 0808 100 3352 on weekdays from 10am to 2pm.

Reporting instead or as well?

MHRA staff try to identify duplicate reports involving the same reaction in the same patient and do not wish to deter anyone from making a report. So it does not matter if two reports are submitted. However, as you can discuss this with Mr H, it would be better to submit only one. As you did not supply the product, it may be more appropriate for Mr H to report.

How can you help?

If necessary you can help Mr H complete the form. As skin rashes can develop to excipients or active ingredients, try to include as much detail as possible. Advise describing the rash in detail too and check he knows to include information about other medicines Mrs H is taking.

What will happen next?

He will receive a copy of the report from the MHRA who may ask for more information. You can explain that the report will be added to the large database of reactions and will be used with all other reports and information to help identify previously unidentified safety issues or side effects.

Professor Janet Krska is professor of pharmacy practice, Liverpool John Moores University.

Get an RPSGB-approved CPD certificate for your portfolio when you successfully complete the 5 Minute Test online. See opposite for details.

The reference is online at www.chemistanddruggist.co.uk/update

NEXT WEEK'S UPDATE
Eating disorders – the main types and their treatment

Drug-induced skin reactions – recording your CPD

Reflect

What are the most commonly implicated photosensitising drugs? How can patients report adverse drug reactions?

Plan

This article describes the different drug-induced skin reactions including urticaria, angioedema and photosensitivity and the drugs most likely to cause them, with advice about helping patients report ADRs.

Act

Read the full version of this article at www.chemistanddruggist.co.uk/update, which describes Stevens-Johnson syndrome and toxic epidermal necrolysis.

Find out more about drug-related skin reactions from at www.patient.co.uk/reference/Drug_Eruptions.htm.

Update your knowledge of urticaria and angioedema on the British Association of Dermatologists' website at http://tinyurl.com/q3jvoy.

Read more about drug-induced photosensitivity on the Dermnet (New Zealand Dermatological Society) website at http://tinyurl.com/qwtg3u.

Read the author's previous three Update articles on ADRs at www.chemistanddruggist.co.uk/update.

Look at the pharmacy section on the MHRA website at http://tinyurl.com/ctyzsa, which has information on drug alerts, dealing with patients and reporting ADRs.

Evaluate

Are you now familiar with the drugs that may cause skin reactions and the types of reactions they can cause? Could you help patients report ADRs?

5 minute test

What have you learned?

Step 1

Step 2

Step 3

Registering for Update 2009 costs £32.50 (inc VAT) and can be done easily at www.chemistanddruggist.co.uk/update or by calling 01732 377269. Signing up also ensures that C+D's weekly Update article is delivered directly to your inbox free every week with C+D's email newsletter.

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Practical Approach

Methotrexate interaction: what must you do?

At the Update Pharmacy a patient has presented a prescription from a consultant rheumatologist at a local hospital for methotrexate 7.5mg weekly and amoxicillin 500mg capsules 1 tds for five days. Pre-registration pharmacist trainee, Joanna, takes it to pharmacist David Spencer.

"I've checked this out on the computer, David," Joanna says, "and it comes up with a 'red light' interaction warning. The BNF confirms that the interaction between methotrexate and penicillins is potentially hazardous, as excretion of methotrexate is reduced increasing the risk of toxicity, and advises that the combination should be avoided.

"What should we do about it? I wouldn't want us to be held responsible if the patient is harmed."

"What do you think we should do about it?" David replies.

"Contact the prescriber, I suppose, and ask him to change the antibiotic to one that doesn't interact with methotrexate."

"I certainly agree we should contact the prescriber, and that's what I'm going to do," says David.

Fifteen minutes later David returns from his office and says to Joanna: "I managed to contact the prescriber about the methotrexate/amoxicillin script.

"He was very polite and thanked me for raising the issue with him, but he was quite sure that he wanted the patient to have both drugs and said I should go ahead and dispense it."

"So are you going to?" Joanna asks.

Questions

1. How serious is the risk of the interaction between methotrexate and amoxicillin?

2. David assessed the risk himself. Which other sources besides the BNF might he have gone to for authoritative information?

3. Did David dispense the prescription? If so, did he take any action to minimise his liability? If not, what did he say to the patient?

Answers

1. Since 1986 there appear to have been fewer than 20 cases published worldwide of interactions between methotrexate and penicillins, and only two of those involved amoxicillin, although in one the patient died. On this basis, according to Stockley's Drug Interactions (see below), there is not enough evidence to forbid concurrent use, although close monitoring is advised. The Summary of Product Characteristics (SPC) for Amoxil (proprietary brand of amoxicillin), issued by the drug's manufacturer, makes no mention of interaction with methotrexate.

2. Stockley's Drug Interactions (8th edition, 2007; Pharmaceutical Press) or the RPSGB's or NPA's information services, which would probably have given their information from the same source; the pharmacy at the hospital where the rheumatologist works, to find out how it deals with this combination if prescribed; the SPC for Amoxil.

3. He did dispense the combination. As a safeguard and clinical governance measure he made an entry in the pharmacy's critical incident log, outlining his actions and conversation with the prescriber. He did consider asking the consultant for a note confirming his decision, but decided it was not necessary in view of the steps he had taken and that he had used his professional judgement in deciding to dispense.

Correction

The answer to question three for the Practical Approach article "What has caused a 'funny turn'?" (C+D, June 6, p19) contained a formatting error. The correct answer can be viewed at http://tinyurl.com/pracapp0606. C+D apologises for the error.

Hundreds of thousands of people in the UK have coeliac disease and don't even know it. This presents a huge opportunity for pharmacists to help patients manage their condition, finds **Chris Chapman**

Gut instinct

Imagine if you couldn't eat cakes or biscuits, that a packet of crisps was out of bounds and a piece of toast or a bowl of spaghetti caused abdominal pains. Now imagine that an estimated half a million people in the UK are currently living with this condition – and don't even realise it can be treated.

According to Nice, one in 100 people in the UK are estimated to have coeliac disease. But the number of diagnosed patients is only the tip of the iceberg, a mere 10 to 15 per cent of patients with the condition.

According to PSNC only two PCTs – Northamptonshire and Cornwall & Isles of Scilly – offer a gluten-free foods local enhanced service. So what can pharmacists do to get involved?

Detection

Patients with coeliac disease can present with a variety of symptoms, including diarrhoea, recurrent abdominal pain and prolonged fatigue. Other signs and symptoms include sudden or unexpected weight loss, unexplained anaemia and persistent or unexplained nausea and vomiting.

Dr Sohail Butt, a GP and member of charity Coeliac UK's advisory board, believes pharmacists are key in detecting undiagnosed coeliac disease that may resemble irritable bowel syndrome (IBS).

"The symptoms of coeliac disease can easily be thought to be due to IBS," Dr Butt says. "Pharmacists are an important link in the chain, and can be instrumental in helping patients gain a correct diagnosis as they are regularly asked about IBS symptoms and relief."

Coeliac disease is also associated with other conditions, including type 1 diabetes and dermatitis herpetiformis – a characteristic itchy rash. Mouth ulcers are also more common, and children with coeliac disease may be short and have a low weight for their age. Between 4.5 and 12 per cent of first-degree relatives of coeliac patients will also have the condition.

Home-testing kits for coeliac disease are available. However, the kits can show a negative result if the patient's diet is already low in gluten.

Management

There is only one treatment for coeliac disease: a gluten-free diet. While gluten-free ranges are available from supermarkets, according to gluten-free product manufacturer Juvela around £28 million of gluten-free prescriptions are dispensed annually in the UK.

Wendy Griffiths, a Cardiff pharmacist who won a 2007 Coeliac UK Supporter Award, says a host of gluten-free products are available, but many patients are unaware of the range of options. She believes it's essential to engage with patients and explore diet options to ensure a healthy diet.

She says: "We try to come up with different ideas. I have a cookery magazine and if we come across a recipe someone likes we try to pass it on."

Malnutrition in patients with coeliac disease is common and patients often don't get enough gluten-free carbohydrates. PSNC head of NHS services Alastair Buxton says there's an opportunity waiting to be grasped by offering repeat dispensing services for local GPs.

He says: "The coeliac services commissioned by PCTs have been a way to try and manage that process out of the GP surgery, so GPs aren't dealing with prescriptions for loaves of bread."

However, there are drawbacks to supplying gluten-free produce that often rule out community pharmacies: loaves of bread are bulky items with a short shelf life. As a result, Ms Griffiths says she can only support a limited number of patients at any one time.

"The bulk is just unbelievable," she says. "If I have three patients at the same time and we're waiting for them to pick it up, we are aware we're walking around it."

But management isn't just about a patient's diet. Patients often suffer from anaemia, and may need folic acid or iron supplements and B_{12} replacement therapy. In addition, coeliac disease can prevent calcium absorption, and patients may need calcium and vitamin D supplements.

And once malnutrition is controlled, patients may put on weight. Gluten-free fibre supplements may be required for patients with constipation, and patients with coeliac disease are more likely to develop intestinal malignancies.

These complications mean managing patients with coeliac disease is a challenge. But with around half a million undiagnosed cases, and a regular patient group that would benefit from a repeat prescribing service, the management of coeliac disease is an area with potential for development.

Further information

The Coeliac Disease Resource Centre runs a training programme for pharmacists.
www.cdrc.org.uk
Coeliac UK is a charity for coeliac patients, offering support, guidance and diet guides.
www.coeliac.org.uk
Nice has recently issued guidance on the diagnosis and management of coeliac disease.
www.nice.org.uk/CG86

What foods contain gluten?

- **Any foods containing barley, rye, oats and wheat contain gluten. These can include bread, biscuits, cereals, pasta and crisps (which often contain dough).**
- **Patients should be advised to read the product ingredients: if they do not mention barley, rye, oats or wheat, the product is gluten-free.**

Product news

Kolanticon safe for coeliacs
Kolanticon is gluten-free and safe for patients with coeliac disease, a medical adviser to The Gut Trust has said. Nick Read described the IBS product, which contains antacids, an antispasmodic and a deflatulant, as "a useful adjunct to treatment" while patients are waiting for a diagnosis to be confirmed.

Price: £3.81/200ml, £4.82/500ml
Peckforton Pharmaceuticals
Tel: 01270 582255

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HOLDER OF MARKETING AUTHORISATION: Reckitt Benckiser Healthcare (UK) Limited, Dansom Lane, Hull HU8 7DS.
DATE OF PREPARATION: April 2009.
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Focus on... the polypill

A hard-hitting report claims combination treatments – polypills – could prevent many lives being lost through cardiovascular disease. **Gavin Atkin** investigates

In the vision of the future presented by the University of London's Professor David Taylor and Eman Al Saeed, pharmacists are key to slashing the burden of heart disease and stroke in the UK. In their recent report, the authors say the profession can do so while addressing the nation's health inequalities – one of the greatest health issues of our time.

And just how are they going to do it? The answer lies in the polypill.

Hard on the heels of the TIPS trial of the Polycaps capsule polypill, which suggested low-dose combination medicines could help halve death and disability rates, Professor Taylor and Mr Al Saeed produced a hard-hitting report entitled Winning Combinations, which argues the case for polypill-style treatments together with successful promotion of protective lifestyles.

Supplying the polypill as well as counselling patients, safeguarding against unwanted side effects and supporting effective lifestyle change, would allow medical resources to be focused on treating individuals with more complex needs, the authors argue.

Put like this, it's difficult to imagine why anyone would argue with the polypill concept, but argue they do. Despite the polypill's promise, progress on the concept has been described as glacial in the six years since epidemiologists Professor Nicholas Wald and Professor Malcolm Law proposed the idea in a paper published by the BMJ. Trials have been limited and few.

So what are the concerns holding the polypill back? Some say it's a ruse to enable drug manufacturers to make new money from old drugs. Others say it will prevent prescribers from tailoring treatments either to match the needs of individual patients or in reaction to their different responses to treatment.

Some argue formulation problems make the polypill impractical. Another point of view is that giving patients 'lifestyle' tablets will discourage them from adopting healthier habits, such as taking more exercise and improving their diet. And yet another school of thought says to treat people for risks they don't appear to have is to over-medicalise their condition.

All of these points of view have support from health professionals – so exactly how do Professor Taylor and other proponents defend the polypill?

The proposition that the drug makers have deliberately floated a seductive idea to make money from older treatments doesn't stand up, observes Professor Taylor, not least because it's too late – the drugs concerned are all off-patent.

On the question of flexibility, he argues that creating a default position in which over-55s are offered a polypill would not prevent individuals being given specific treatments if they are needed.

Tracy Dominey/Science Photo Library

> 'WE HAVE TO BALANCE THE NEED FOR CAUTION AGAINST THE SHEER FOLLY OF WAITING TOO LONG [FOR THE POLYPILL]'

"If you say here's the basic offer for the mass of the healthy over-55s, it's not the same as saying it's one size fits all," he says. "If it becomes clear a patient is at special risk and needs a completely different set of treatments, there's no reason why they should not have it.

"What's more," he warns, "cardiologists tell me the personalisation of drug treatment too often leads to the use of sub-optimal combinations that are not as rational as fixed dose combination products based on the best available evidence."

Professor Taylor agrees there might be difficulties in creating and establishing polypills for vascular disease prevention, but suggests they should not be insuperable for a drug industry that succeeded in creating practical combination treatments for HIV. He also rejects the charge that creating a lifestyle tablet would be regarded as an alternative to changing unhealthy behaviours. That argument, he says, comes from a defensive public health establishment that has traditionally focused on exercise and diet and is sometimes hostile to pharmaceutical approaches.

On the issue of over-medicalising, Professor Taylor argues in favour of protective medicines-taking and points out that the potential benefits of reducing vascular disease risk across the whole population aged over 50 or 55 are enormous.

"There are currently 200,000 CVD-related deaths a year in the UK. Let's suppose that in five to 10 years the polypill could be saving an additional 10,000 lives a year and many more cases of disability. If we delay by a year, we will not have saved those lives. There is a potential cost to not introducing the polypill.

"Of course, there are hazards in everything, but the danger of making a mistake with products that have been on the market for decades and where, in reality, we already use them in combination, is terribly small. We have to balance the need for caution against the sheer folly of waiting too long."

But there is more to this story. One of Professor Taylor's key arguments is that the polypill concept shows the way to a new approach that addresses the risks of entire communities instead of treating only those individuals whose tests and measurements place them in an arbitrarily defined high risk group.

"The big numbers in terms of potentially avoidable loss of life years or disability are not necessarily in the high risk groups but in the medium risk groups, which is where most people can be found," he says. "We have a medical culture that regards hypertension, diabetes or hypercholesterolaemia as being defined by a certain threshold measurement but, as Nicholas Wald has pointed out, most risks don't suddenly disappear below a certain level.

"Wider use of existing established medicines – either in polypills or other presentations – could be used to shift the entire normal distribution curve instead of just picking off people at one end of it and treating them as patients." This, says Professor Taylor, is where some of the big public health wins of the future may lie.

"What we haven't got yet is statistical modelling that includes diet and exercise along with drug treatments that would allow us to see the contributions that each can make in different combinations. Getting drugs and lifestyle to work together in complementary ways could add up to something much more potent than our current approach."

References

Al Saeed, EA; Taylor, D (2006) Winning combinations: towards new models of preventive personal and public health care [online] London: The School of Pharmacy, University of London. www.pharmacy.ac.uk/1959.html

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Pharmacists and manufacturers continue to accuse each other over persistent UK drugs shortages. But **Chris Chapman** and **Jennifer Richardson** think it's time to focus on solutions and stop the recriminations

Getting drug stocks flowing

Quotas. A word currently sending chills up the spines of pharmacists around the country. Over the past months contractors have reported increased difficulty obtaining medicines. Out of stocks lists at some pharmacies have extended to three pages, with Arimidex, Zyprexa, Cellcept, Neoral and Keppra being difficult, if not impossible, to obtain.

Manufacturer quotas seem to be the scapegoat when it comes to this drugs drought. But are they the real problem?

Contractors certainly believe so. VJ Mithani, of VSM Pharmacy, Camberley, says quotas are "very detrimental" in a supply situation that's getting worse day by day. His voice is supported by other community pharmacists around the country. And according to PSNC, independent contractors spend around one hour every day sourcing medicines for patients.

And yet manufacturers insist quotas are a vital element in protecting medicines supply. Nick Francis, head of communications at Eli Lilly, insists that direct-to-pharmacy sales and quotas are the only way manufacturers can ensure the drugs pipeline leads to UK patients.

He says: "If we can see who's ordering, and where it's going, we can ensure supply. By entering into arrangements it will give us a visibility of out of stocks."

Mr Francis says the main reason behind quotas is to prevent parallel exports diverting medicines from the UK supply. He is supported by others in big pharma. The Association of the British Pharmaceutical Industry say 4 per cent of the UK market is being exported abroad. Last week, ABPI commercial director David Fisher told C+D there would be "complete anarchy" if quotas weren't in place to protect the stream (C+D, June 13, p5).

And Paul Johnson, of IMS Health, says the ABPI's comments are supported by evidence. "The level of product manufacturers are putting into the marketplace meets the total UK demand as we measure it, so it does appear to be exports. I would say that quotas have been necessary to protect supply," he says.

However, parallel exporting is perfectly legal. And according to the British Association of European Pharmaceutical Distributors (BAEPD), overall trade around the EU hasn't changed. BAEPD secretary-general Richard Freudenberg likens parallel trade within the EU to a balloon: where one area expands, another reduces.

The weak pound has made parallel exports an attractive proposition, while conversely causing the imports market to shrink. Mr Freudenberg says there has been a 40 to 50 per cent fall in a trade that added 60 million packs into the UK market in 2007, creating a current shortfall of 25 to 30m packs.

Grassroots pharmacists have noticed a soar in demand for drugs for export. Amish Patel, of Hodgson Pharmacy in Dartford, says he's been approached several times by wholesalers with offers to buy drugs so they can be exported.

"We don't parallel export," he says, "but I have been approached by a number of companies that ask us 'can you buy this in?' and so on – the drugs [manufacturers] put quotas on. So the quotas do protect against parallel exports."

But is parallel trading too simple an answer for the current shortage? Community Pharmacy Scotland's Alex MacKinnon points out that parallel trade has gone on for years. He says quotas are definitely the root cause of Scotland's medicines troubles.

"We don't believe the level of exporting in Scotland is what's causing the problem," he says. "We believe it's the severity of quotas and the approach taken."

Perhaps the problem is a combination of the two. Martin Sawer, executive director of the British Association of Pharmaceutical Wholesalers (BAPW), says it's an oversimplification to say parallel exports or quotas are to blame: both are part of the problem.

He says: "I think it's more complicated than just parallel exports. They are a factor, but I do agree strongly... that quotas are tight and inflexible."

Mr Sawer says the solution is to improve communication between manufacturers and wholesalers, so that wholesalers can spread out supply and ease the impact of any shortages that occur.

And Sue Sharpe, chief executive of PSNC, says that while parallel trading is an issue, manufacturers are not taking enough responsibility for the situation. The time has come, Ms Sharpe says, for government intervention.

"There is now clearly a need for regulatory action to solve the problem... the Department of Health will need to find a way of doing so that is compatible with European competition laws."

Bharat Shah, managing director of Sigma Pharmaceuticals, suggests a way forward. He says the solution is to change the pricing structure of medicines, ensuring both UK supply and parallel trading.

He says: "I think a solution to this problem is to do a dual pricing for UK and exports stocks. If a pharmacist needs more than his allocated demand in a month, he supplies proof and gets the stock."

But ultimately it doesn't matter where the fault lies, suggests Mark James, group managing director of wholesaler AAH Pharmaceuticals.

Mr James says that leakage from the supply stream caused by parallel exports can never be reduced to an absolute zero. He believes manufacturers have to make an allowance for the constant trickle and overestimate UK drugs demand.

"Providing 100 per cent of estimated UK demand, on an attractive product for export, will result in shortages to UK patients," he says.

"All those involved in the pharmaceutical supply chain need to move beyond blaming each other and start working on solutions," Mr James says. "That will involve compromises."

Where you can do

- Let C+D know which stocks are hard to obtain. Email cchapman@cmpmedica.com
- PSNC is monitoring stock shortages and will feed evidence to the Department of Health. Report supply problems at www.psnc.org.uk or by calling 01296 432823.
- Community Pharmacy Scotland wants pharmacists to send specific examples of stock shortages in Scotland. Email enquiries@communitypharmacyscotland.org.uk or call 0131 467 7766.

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Cut costs, not jobs

There are several ways businesses can reduce staffing costs without losing people, says employment lawyer **Adam Rice**

If you don't know someone who's had to go through the trauma of job cuts at their company in the past year, you must have a collectively lucky group of friends. Job losses continue to make weekly, if not daily, headlines as the recession persists, and while pharmacy is arguably more credit crunch-resistant than some sectors it is certainly not immune.

Pharmacies from independents and small chains to the UK's third largest multiple, The Co-operative Pharmacy, have all had to make staff cuts over the last 12 months. But there are ways businesses can attempt to reduce their staffing costs without reducing the number of people they employ – all with different legal obligations for the employer and options available to the employee.

In the current economic climate, employers might consider: changing shift patterns or reducing overtime; cutting back on benefits such as contractual sick pay, holiday pay and private medical insurance; freezing wage levels or minimising bonuses.

Some of these changes may be authorised by the employment contract or the contract might allow the employer to withdraw a discretionary benefit at any time. However, even if a benefit is non-contractual or discretionary, the employee may still be entitled to it if it has been provided consistently over time.

If employees refuse to agree to such changes, employers may try to impose a change unilaterally, arguing that those who continue to work without protest by implication agree to the change. The implied agreement test is more likely to be met if the change has an immediate impact, such as a pay cut, than if the change is not felt for some time, such as cuts to redundancy pay or pensions. However, employees who object to the changes may resign and claim constructive dismissal or refuse to work under the new terms, forcing the employer either to dismiss them or let them continue on their old terms. Perhaps more likely in the current climate is for an employee to agree to work 'under protest' and seek damages for any loss they suffer as a result of the change.

Adam Rice: a bit of lateral thinking on cost cutting can save jobs

Employers with good business reasons for cutting pay or benefits may dismiss employees and re-engage them on revised terms if their earlier attempts to persuade employees to consent to the change have failed. Provided employees are given proper notice of dismissal, there can be no claim for breach of contract. Conversely, employees may have unfair dismissal claims, but employers who have acted reasonably by consulting with employees about possible alternatives will have a better chance of defending these, particularly if the employer can show that jobs would be at risk or the business would suffer if cut-backs are not made.

Can employers facing financial difficulties cut back on staff bonuses? The answer depends largely on whether the bonus is contractual. If it is, and the employer has promised to pay a particular bonus, it is difficult to go back on that. An entitlement to a bonus might be found not only in the employment contract, but also in a verbal promise or an email from a manager, or through custom and practice where the bonus has been paid year on year. In these circumstances, failure to pay is likely to be a breach of contract, giving the employee the right to claim damages or resign and claim constructive dismissal.

On the other hand, if the bonus is discretionary, employers will usually have greater scope for reducing its size. Provided objectively justified factors are considered and clearly documented, it will be difficult for an employee to challenge the size of a discretionary bonus.

However, even discretionary bonus schemes may not allow nil payments; depending on the bonus criteria and targets, a refusal to pay a bonus at all may be an unreasonable exercise of the employer's discretion.

Unless the employment contract specifically allows for reducing the hours staff work, it can only be done by agreement with employees.

Without agreement, forcing employees to work reduced hours and take a pay cut would, almost certainly, give employees the right to resign and claim constructive dismissal.

Other practical ways of temporarily reducing salary costs may include encouraging staff to take sabbaticals or unpaid leave. Alternatively, employers can seek requests from staff to work flexibly through part-time, home-working or job-sharing.

Adam Rice is a specialist in employment law at City solicitors, Travers Smith

Career tip of the week

"Do your homework prior to applying for a job. Find out about the company, obtain an annual report if available, find out what future projects the company might be involved with, who its clients are and who its competitors are."
From Brilliant CV, by Jim Bright and Joanne Earl
www.chemistanddruggist.co.uk/booksforjobhunters

brilliant CV

Your questions answered

Q I've given a member of my pharmacy staff extra responsibilities but she's not coping very well. What should I do about it?

Ian Irving, HR business partner at Co-operative Healthcare, responds:

A The first thing you need to do when you give extra responsibilities to any employee is to ensure that they have the capacity to cope with the work. It is essential to be clear about what you expect and ensure that the employee understands this. It also makes sense to agree how long you want the employee to carry out the work – for example, is it four weeks or three months – and build in a review period as part of any regular one to one meeting you have with them.

Having set out your expectations, you need to monitor how they are coping. If things are seemingly not working you must put aside some time and discuss your observations with them. Always first ask the employee how they think it's working; often they will be open and tell you how they feel without you having to go through the pain of telling them they're not coping very well. No one likes to hear that their performance is not as you would expect so trying to get them to tell you that they feel it's not working is a much better approach.

The key message is, don't ignore the issue. The sooner you talk to the employee the better chance you have of resolving it. Your quick intervention might also help to identify what is causing the problem, which could be the difference between taking the extra work from them or letting them carry on with it.

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Postscript...

Mike Hewitson's diary of a new pharmacy owner

No quitting on the quitters

Success! At last, patients are starting to use some of the new services we have to offer. In the past week we have taken on our first Smokestop client, and have been able to provide speedy access to emergency contraception for the younger members of our community. What's more – it felt good!

While I still believe it is dispensing that pays our bills, it is great to have services as a new source of income for our business, particularly when it looks like we're about to take a hit on next month's category M.

My Smokestop client came to me as a direct referral from one of our local GPs, which makes me feel more optimistic about the future of multidisciplinary team working in our town, and makes me want to succeed in helping the patient even more. Having gone through my training for this service back in February it is great to finally have someone I can help. In a few weeks time my quit rate will either be 100 per cent or it will be a big fat zero, but it won't be for the want of trying.

The patient arrived five minutes before lunch, but there was no way I was going to give him any excuse not to quit – so we worked through it. Hopefully we will both be successful, which would be a massive boost to my confidence in the service and the excellent remuneration that is on offer in Dorset.

The only thing is, getting the patient to quit might be the easy part – you haven't seen the paperwork!

> IN A FEW WEEKS MY QUIT RATE WILL EITHER BE 100 PER CENT OR A BIG FAT ZERO

Raiders of the lost archives

C+D 1859-2009 Celebrating 150 years in pharmacy

How do you solve a problem like the adulteration of medicines? A bill from March 1860 suggested the solution was to name and shame those responsible.

"Every dishonest shopkeeper who knowingly sells an article of food or drink... injurious to the health of the purchaser... is liable to be brought before two Justices of the Peace," stated the bill. If found guilty, a first offence would have been punishable by a fine of several pounds and pence.

It might sound lenient, but the gloves really came off for a second offence. "If convicted of a second similar offence, his name and crime will be published at his own expense, the choice of the advertising medium being left to the 'two justices'."

While Postscript likes the idea (and would choose a giant advertising balloon as its medium, in case you were wondering), C+D's editor in 1860 wasn't a fan. He slammed the bill's designers as "unskilful though well-meaning" and refused to endorse it.

Spoilsport.

Pharmacy rocked by vote fixing scandal?

Last week, pharmacy was rocked by its biggest scandal since pharmacy minister Phil Hope announced he was to pay back £40,000 of expenses: someone may have tampered with C+D's online Dispensary Talk poll.

We know. Shock, horror. Grab your pitchforks and burning torches. If the result of an online C+D poll isn't safe, what is?

On the Monday, the poll for the most popular recent RPSGB president showed Steve Churton with a healthy 70 per cent of the vote. Gillian Hawksworth had less than 10 per cent. Then, in one evening, the number of votes doubled: all of them supporting Ms Hawksworth.

A voting race between the two fanbases gathered pace, and by the time the poll closed the number of votes cast were for more than the previous three Dispensary Talks combined.

Postscript isn't suggesting either candidate was involved. And maybe they're just really popular. And their supporters like to vote en masse. On a Tuesday. Perhaps while parading around with a little figurine of their fave president.

But Postscript thinks something smells a bit fishy, and will keep an eye out for any irregularities in future polls.

Onscreen chemistry creates typecasts

Fictional pharmacists are always moustache-twirling villains or mildly psychotic, it seems. Postscript has already mentioned the murderous pharmacist in Desperate Housewives, the slavery-condoning pharmacist in Family Guy and the zombie-slaying pharmacist in 28 Days Later. Now a new show from the USA has introduced another variation: the drug-dealing sex maniac pharmacist.

Nurse Jackie is a new black comedy starring Sopranos star Edie Falco as the title character, who treats patients while zonked out on opioids supplied by her pharmacist lover, Eddie.

TV channel Showtime describes the pharmacist as a man who "showers Jackie with love and the painkiller Percocet", adding: "Eddie is sleeping with Jackie in the pharmacy from time to time."

So, another good role model for young pharmacists, then...

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*Please note that those ordering the course materials only, and subsequently deciding to register, will have to pay the full registration fee of £150.

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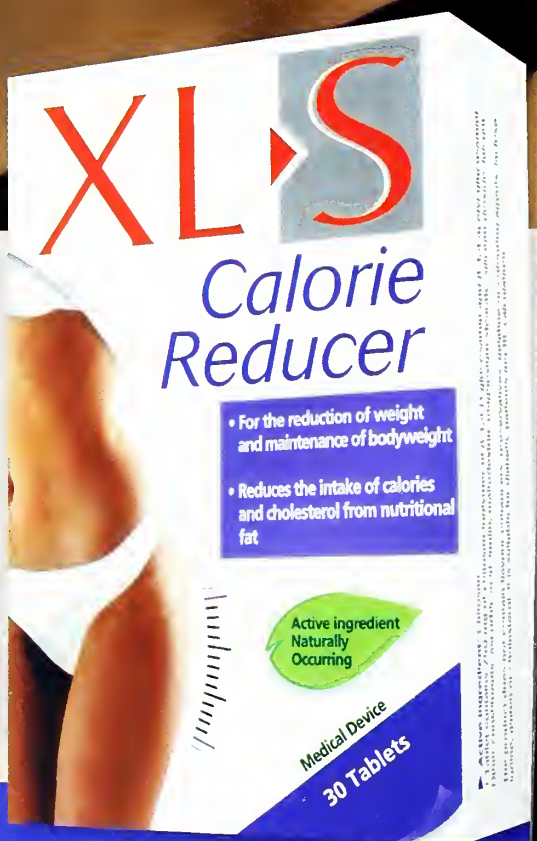

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